Instructions for responding to Requirements Workbooks:

These requirements have been formatted into workbooks as a more efficient and effective way not only for a vendor to respond; but for KHPA to evaluate as well.

The workbooks have been compiled by category. Within each category subsections have been broken down into worksheets and placed into tabs that have been labeled accordingly.
Within the worksheets notice that after the "Requirement" column the columns proceed as followed: "Requirement for Phase 1, Response, Explanation of Response and Response Reference."
The purpose of each column is defined below.

- Implementation Phase - Respond with a 1, 2 or 3 to indicate the anticipated phase of implementation (A detailed description of the three phases can be found in the RFP.)
- Response - is the column where the proposer will respond to whether or not the requirement is met and to what extent. (Detailed instructions below.)
- Explanation of Response - Please provide an Explanation of how the requirement is or isn't met and validate the (0-5) rating given in the "Response" column.
- Response Reference - Please indicate where, throughout your response proposal, this is described in detail.

Proposer Fit Rating Response Codes: In the "Response" column please provide a Yes or No indicating whether or not the requirement is met. In addition to Yes or No, include a number rating indicating to what level the proposed solution meets the requirement. (Example of Response – Yes/3)
Fit Rating 5: Solution meets the requirement without any customization or configuration to implement.
Fit Rating 3: Solution mostly meets the requirement, but will require minor customization or configuration to implement.
Fit Rating 1: Solution somewhat meets the requirement, but will require significant customization or configuration to implement.
Fit Rating 0: Solution does not meet the requirement at all, and cannot do so through customization.
(Rating system and brief explanation can be found at the top of each worksheet as a reference tool.)

Please note that some requirements have been highlighted. These requirements have been deemed optional and KHPA requests pricing be cost out separately for the indicated requirements. Please Respond to these under the "Optional Costs" in the Separate Cost Proposal.

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Function: Presumptive Eligibility Module (PETL) - A complete eligibility determination system specific to providing presumptive eligibility. Used by designated entities throughout Kansas located at various medical clinics and hospitals. Captures demographic information about the household, determines PE eligibility and submits the determination to the HealthWave office.

Req #	Requirement	Implementation Phase	Response	Explanation to Response	Response Reference
PETL-001	Must capture, allow change, retain and display information required for eligibility determinations. (e.g. PE submit date, PE date of service, income, house hold composition, etc.)				
PETL-002	Must capture, allow change, retain and display individual consumer demographic information. (e.g. name, birth date, age, SSN, citizenship status, etc.)				
PETL-003	Must automatically determine PE eligibility for multiple medical programs and benefits based on eligibility criteria and hierarchy.				
PETL-004	Must allow PE entities computer system to interface with the online PE tool. This allows the entity to auto populate the PE tool with data already captured in the entity's system.				
PETL-005	Must automatically determine eligibility start date.				
PETL-006	Must automatically reject incomplete PE application.				
PETL-007	PE tool must auto populate the online application.				
PETL-008	Must accommodate diverse populations of users including those with visual and hearing impairments, persons with low and moderate educational levels, and the elderly. (508 compliant) http://www.section508.gov/				
PETL-009	Must direct the entity to the next logical step based on previous responses. (e.g. Males are not asked about pregnancy)				
PETL-010	Must route the PE determination to the designated staff person or work queue (KHPA or contractor). The subsequent online application must be routed to the same designated staff person or work queue.				

PETL-011	When a subsequent online application is submitted, must auto identify the non PE application originated from a PE determination.				
PETL-012	System must create a window that will allow the PE entity to print a temporary PE medical card with applicable eligibility start date.				
PETL-013	Must automatically create PE notices.				
PETL-014	Must automatically suppress PE notices.				
PETL-015	Must allow user to manually create PE notices.				
PETL-016	Must allow user to manually suppress PE notices.				
PETL-017	Must automatically create a customer release/authorization to contact.				
PETL-018	Must automatically generate a customer release/authorization to contact to be sent.				
PETL-019	Must allow user to manually create a customer release/authorization to contact.				
PETL-020	Must allow user to manually generate a customer release/authorization to contact to be sent.				
PETL-021	Must automatically track status of customer release/authorization to contact.				
PETL-022	Must identify a consumer who has had previous PE coverage and prevent a new PE determination.				
PETL-023	Must identify a consumer who is currently receiving medical benefits if they are known to the system.				
PETL-024	Must automatically establish the assistance plan and household size for the PE determination.				
PETL-025	Must provide a quality assurance module to track entities' decisions.				
PETL-026	Must provide indication of met, failed or potential eligibility for all medical program’s eligibility criteria at initial determination and any time eligibility is redetermined. If failed include reason(s) for failure. If potential, identify gaps.				
PETL-027	Must notify the appropriately designated staff or work queue that an application and/or PE tool has been submitted. (e.g. provide a hyperlink.)				
PETL-028	The entry screen must display a brief description of the online PE tool as well as links to policy and training related to the PE determination.				
PETL-029	Must capture the name and phone number of staff completing the PE tool.				

PETL-030	Must automatically indicate the name, address, and phone number of the entity the PE tool was submitted from.				
PETL-031	Must automatically confirm acceptance of complete PE determination.				
PETL-032	Must allow the entity to place a PE determination on hold and complete at a later date.				
PETL-033	Must provide multiple options for the entity to retain a copy of their PE determination. This is to include but not limited to print, 'save-to-file.'				
PETL-034	KHPA requires piloting the application system (PE, Self Assessment and the Online Application - PHASE I) prior to full implementation. KHPA will use the existing PE providers at the time of implementation as the pilot locations.				
PETL-035	During the pilot the vendor must provide a lock-out solution that will allow only designated pilot participants to access the online system (such as a pilot only login page).				
PETL-036	Must provide full technical support as needed during the pilot phase.				
PETL-037	Must provide updates to KHPA as agreed regarding issues identified during the pilot as well as proposed solutions to resolve any issues.				
PETL-038	Must maintain an Issue log for all calls received throughout the pilot phase.				
PETL-039	Must have any issues identified during the pilot phase resolved within 5 business days of completion of the pilot.				
PETL-040	Must provide a summary page of information entered and must allow the user to edit from that page.				
PETL-041	Must automatically save information as entity completes PE determination.				
PETL-042	Must timeout when the PE tool has been idle for a set time. This time will be defined by KHPA.				
PETL-043	Must allow automatic expiration of incomplete PE determinations. Will notify entity of incomplete determination prior to exiting system.				
PETL-044	Must retain completed PE applications and determination in accordance with the retention schedule. All applications must be easily retrievable.				

PETL-045	Must provide reports to monitor the Presumptive Eligibility program. These will include the following specific reports, with additional reports to be added as need requires:				
PETL-045.1	Provide a report that identifies the total number of PE determinations completed per entity, with details regarding the number of approvals/denials, denial reasons and program approved.				
PETL-045.2	Provide a report that identifies the percentage of PE determinations completed per entity where a subsequent HealthWave application is received.				
PETL-045.3	Provide a report that identifies the HealthWave application outcome with details regarding the number of approvals/denials, denial reasons and programs approved.				
PETL-045.4	Provide a report that identifies the percentage of PE determinations that result in approval of HealthWave coverage.				
PETL-045.5	Provide a report that identifies PE determinations submitted to the Clearinghouse within two business days.				
PETL-045.6	Provide a report that identifies the average number of dates to process the HealthWave applications associated with PE determinations.				

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Function: Registration (REGI) - Enter the captured information into the system to establish a case with a unique identifying individual number. (These numbers will be unique to each case and individual.)

Req #	Requirement	Implementation Phase	Response	Explanation to Response	Response Reference
REGI-001	Must automatically assign a unique client identifier (High Level Client Index).				
REGI-002	Must automatically create a case by grouping associated customers together. (e.g. A case is a group of family members, members who are part of the same household or are part of a mandatory filing unit, etc.)				
REGI-003	Must allow user to manually create a case. (e.g. A case is a group of family members, members who are part of the same household or are part of a mandatory filing unit, etc.)				
REGI-004	Must automatically assign a customer to a case.				
REGI-005	Must allow user to manually assign a customer to a case.				
REGI-006	Must automatically use an existing case number when appropriate.				
REGI-007	Must automatically assign a unique case number to a case.				
REGI-008	Must have ability for a member to be associated to multiple cases at the same time. (e.g. member may receive medical benefits on one case number and be the case name for a different case number on which their child is receiving benefits, etc.)				
REGI-009	Must automatically associate multiple cases to each other. (e.g. cases that share members must be associated to each other, etc.)				
REGI-010	Must have ability to manually associate multiple cases to each other.				
REGI-011	Must automatically associate members to each other. (e.g. children who share an absent parent must show an association, etc.)				

REGI-012	Must allow user to manually associate members to each other.				
REGI-013	Must record receipt of hard copy documents. (e.g. paper applications, review forms, etc.)				
REGI-014	Must allow user to manually create intake. (e.g. member requests determination of eligibility for a new program during a phone call, etc.)				
REGI-015	Must automatically create intake. (e.g. if information learned from an interface suggests entitlement to a different program an application for the new program must automatically be created, etc.)				
REGI-016	Must allow user to record a review without a paper review form.				
REGI-017	Must automatically close a program for failure to complete a required review.				
REGI-018	Must automatically determine if a request is an application, review, case management request, duplicate, etc.				
REGI-019	Must automatically create tasks.				
REGI-020	Must automatically identify and link duplicate applications to the case and member receiving benefits.				
REGI-021	Must capture, retain and display benefit history, request history, program history, etc.				
REGI-022	All histories must be easily retrievable, searchable and be displayed appropriately with the ability to recall date specific eligibility, financial, non financial, demographic, content information, etc.				
REGI-023	Must automatically identify an individual currently participating upon inquiry.				
REGI-024	Must automatically determine eligibility for multiple programs and benefits based on eligibility criteria and hierarchy.				
REGI-025	Must accommodate multiple application forms. (e.g. Family Med only, disability, etc.)				
REGI-026	Must have ability to capture prior medical requests.				
REGI-027	Must automatically establish eligibility periods/dates (e.g. budget period, base period, effective and thru date, review thru date, continuous eligibility date, etc.).				
REGI-028	Must allow the user to manually override automatically established eligibility periods/dates.				
REGI-029	Must automatically set ‘special situation’ indicators. (e.g. Eligible for expedited benefits, case needs immediate attention, special needs associated with this case, etc.)				

REGI-030	Must allow user to manually set ‘special situation’ indicators. (e.g. eligible for expedited benefits, case needs immediate attention, special needs associated with this case.)				
REGI-031	Must allow user to manually override all automatically set ‘special situation’ indicators.				
REGI-032	Must automatically create intake from processing an online application.				
REGI-033	Must automatically create multiple cases. (e.g. Disabled HCBS parent with a HW child - one case would go to the Clearinghouse worker, and the other case would go to the SRS Field office.)				

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Function: Determine Eligibility (ELIG) - This business function covers the application of program policy to financial and non-financial information to determine the programs and level of benefits for which a customer is eligible.

Req #	Requirement	Implementation Phase	Response	Explanation to Response	Response Reference
ELIG-001	Must determine eligibility for multiple medical programs and benefits based on eligibility criteria and hierarchy.				
ELIG-002	Provide the ability to perform completely automated eligibility determinations (without the involvement of a human eligibility worker) upon receipt of an application.				
ELIG-003	Must have the ability to require an eligibility worker to authorize an automated eligibility determination.				
ELIG-004	Must evaluate eligibility criteria against all data available. (e.g. consumer entered information, data already existing in the system, manually entered data, data gleaned from interfaces, etc.)				
ELIG-005	Must provide indication of met, failed or potential eligibility for all medical program's eligibility criteria at initial determination and any time eligibility is redetermined. If failed, include reason(s) for failure. If potential, identify gaps.				
ELIG-006	Must automatically determine mandatory filing unit(s).				
ELIG-007	Must automatically determine assistance plan(s), including multiple plans within groups.				
ELIG-008	Must determine Pro-rata share of resources. (e.g. jointly owned property, etc.)				
ELIG-009	Must determine Pro-rata share of income. (e. g. partial month eligibility, etc.)				
ELIG-010	Must limit program determination when applicable. (e.g. If an applicant requests a determination of eligibility for only the TB program then the system must limit determinations to the TB program only.)				
ELIG-011	Must have the ability to manually override eligibility determination.				

ELIG-012	Must automatically deny an application if the consumer fails to provide required verification.				
ELIG-013	Must automatically redetermine eligibility. (e.g. an SSA SDX record is received and automatically processed for an ongoing SSI Medicaid member. The SDX record indicates the member is no longer in current pay status for SSI benefits due to excess income. The system shall redetermine eligibility for SSI Medicaid for this member and will show the member is no longer eligible for this SSI medical program, etc.)				
ELIG-014	Must have ability to manually initiate a redetermination of eligibility. (e.g. eligibility staff learn of a member's death, enters this information into the system and causes a redetermination of eligibility, etc.)				
ELIG-015	Must determine, capture, allow change, retain and display indicators of possible future eligibility. (e.g. Potential Pickles, etc.)				
ELIG-016	Must have ability to create a holding status following eligibility determination, allowing the customer the opportunity to agree to benefits, obligations, responsibilities, etc. of the program prior to final benefit authorization. (e.g. consumer is eligible for multiple categories and must choose category or must agree to pay premiums prior to benefit authorization.)				
ELIG-017	Must accept applications for persons with a date of death.				
ELIG-018	Must have ability to allow responsible persons and medical representatives and associate them to specific members on whose behalf they may act.				
ELIG-019	Must automatically identify discrepant information. (e.g. address reported by non agency partner is different than address on file, etc.)				
ELIG-020	Must automatically associate multiple cases to each other (e.g. cases that shard members must show an association, etc.).				
ELIG-021	Must automatically associate multiple members to each other. (e.g. children who share an absent parent must show an association, etc.)				
ELIG-022	Must have ability to manually associate multiple cases to each other.				
ELIG-023	Must have ability to manually associate multiple customers to each other.				

ELIG-024	Must have ability for multiple users to access the same case at the same time.				
ELIG-025	Must provide electronic on line scripts for common case maintenance changes based on information reported. (e.g. member reports a disabled child will be entering the home – script must lead staff thru appropriate questions to ask based on the information reported, etc.)				
ELIG-026	Must create forms in multiple formats. (e.g. hard copy, electronic formats receivable by phone, PDA, e-mail, etc.) (Two examples of forms are review forms and referrals.)				
ELIG-027	Must automatically populate forms with information already in the system as well as information learned thru an interface. (e.g. automatic query of non agency partner's computer system indicates earnings, these earning shall be used to populate the review form, etc.)				
ELIG-028	Must track case maintenance actions. (e.g. how many address changes were completed by worker X within a date range, etc.)				
	Determine eligibility/ineligibility periods/dates				
ELIG-029	Must automatically establish eligibility periods/dates. (e.g. budget period, base period, effective and thru date, review thru date, continuous eligibility date, etc.)				
ELIG-030	Must automatically recalculate eligibility periods/dates (e.g. budget periods, base period, effective dates, review thru date, continuous eligibility date, etc.) when changes occur.				
ELIG-031	Must allow manual override of automatically established eligibility periods/dates.				
ELIG-032	Must allow day specific eligibility. (e.g. eligibility for some programs begins the day after the program is authorized and others begin the first of the month for which an eligibility determination has been made, etc.)				
ELIG-033	Must allow month specific eligibility. (e.g. eligibility for some programs begins the day after the program is authorized and others begin the first of the month for which an eligibility determination has been make, etc.)				
ELIG-034	Must automatically identify penalty situations. (e.g. inappropriate transfer of property, etc.)				
ELIG-035	Must calculate and determine penalty period.				
ELIG-036	Must automatically apply penalty period(s) preventing authorization of select benefits (e.g. deny LTC and approve QMB, etc.) during penalty period.				

ELIG-037	Must have ability to manually initiate calculation/recalculation of penalty periods.				
ELIG-038	Must automatically recalculate penalty periods.				
ELIG-039	Must automatically set due dates for action required. (e.g. auto set alert when expected date of delivery is near or review is due, etc.)				
ELIG-040	Must have ability to manually set due dates for action required.				
ELIG-041	Must automatically calculate, retain and display any applicable premium.				
ELIG-042	Must set correct premium amount with the correct effective date.				
	Alert staff to situations				
ELIG-043	Must identify, flag and alert staff when new data is found to be in error or conflicts with known data. (e.g. consumer entered SSN is one digit different than the SSN already known to the system for a consumer with the same name, information learned thru an interface conflicts with existing information, etc.)				
ELIG-044	Must identify, flag and alert staff to outstanding mandatory information.				
ELIG-045	Must automatically notify staff of existing or previous benefits. (e.g. staff initiate action to add a person to an ongoing program, if this person is already a member on another medical program the system will recognize this and alert the worker to the situation, etc.)				
ELIG-046	Must automatically assign program, person, case and action required alerts. (e.g. duplicate ID, potential fraud, non-cooperation, medical subrogation, CSE, age-related, SSI change, etc.)				
ELIG-047	Must have ability to manually set program, person, case and action required alerts.				
ELIG-048	Must notify all appropriate staff when case, program or individual circumstances change. (e.g. benefits are approved, denied, changed, closed, address changes, resource is liquidated, etc.)				
ELIG-049	Must notify appropriate non agency partners when case, program or individual circumstances change. (e.g. benefits are approved, denied, changed, closed, address changes, resource is liquidated, etc.) Notifications may be in the form or an electronic, hard copy or phone communication, etc.				

ELIG-050	Must notify all appropriate staff when changes occur on cases associated with each other. (e.g. staff located in a field office are responsible for a child's HCBS program and other staff located at the Clearinghouse who are responsible for a sibling child's SI program, Mom is case name on both cases, change the address on their case the system must notify the appropriate HCBS staff of this address change, etc.)				
	Capture, Allow, Change and Retain information/history				
ELIG-051	Must capture data from interfaces.				
ELIG-052	Must capture manually entered data.				
ELIG-053	Must capture, allow change, retain and display information required for eligibility determinations. (e.g. income, resources, expenses, living arrangements, screening score, etc.)				
ELIG-054	Must be able to track medical program determinations separately. (e.g. income used to determine eligibility for TXIX may be different than the income used to determine eligibility for TXXI, etc.)				
ELIG-055	Must capture, retain and display all data related to each eligibility determination. (e.g. program(s) for which eligibility was determined all financial and non financial information in place at the time of the determination, etc.)				
ELIG-056	Must capture, retain and display result of each eligibility determination. (e.g. pass or fail for each eligibility criteria at the time of the determination, etc.)				
ELIG-057	Must capture, retain and display all benefit histories.				
ELIG-058	Must capture, retain and display all data values, the date the value is established or changed, the effective and thru dates for the value and who or what process set the value, etc.				
ELIG-059	All Histories must be easily retrievable, searchable and be displayed appropriately with the ability to recall date specific eligibility, financial, non financial, demographic and content information, etc.				
ELIG-060	Must capture, allow change, retain and display individual consumer demographic information. (e.g. name, birth date, age, SSN, citizenship validation and identity validation, etc.)				
ELIG-061	Must automatically set, allow change, retain, and display 'special situation' indicators. (e.g. eligible for expedited benefits, case needs immediate attention, special needs associated with this case etc.)				

ELIG-062	Must have ability to manually set 'special situation' indicators. (e.g. eligible for expedited benefits, case needs immediate attention, special needs associated with this case, etc.)				
ELIG-063	Must have ability to manually override all automatically set special situation indicators, flags, calculated values, etc.				
ELIG-064	Must retain all calculated values for later retrieval.				
ELIG-065	Must create, retain and display referral history including content.				
ELIG-066	Must require, capture, retain and display receipt acknowledgement of information sent to partners.				
ELIG-067	Must automatically associate information to all appropriate cases, members, etc.				
ELIG-068	Must have ability to manually associate information to multiple cases, members, etc.				
ELIG-069	Must provide an integrated auto populated and free format manually populated case log/history. (e.g. log will be auto populated with information learned and actions taken. Phone calls received at the Clearinghouse are auto documented here from an interface with HealthWave vendor phone system and staff are allowed to make free format entries on the same log.)				
ELIG-070	Must have ability to override auto and manually populated case log/history entries.				
ELIG-071	Case log/history must automatically populate date, time and who or what process was responsible for all entries.				
ELIG-072	Must automatically build a case log entry shell using standardized statements (e.g. child support enforcement system is searched the following script would populate the log and allow manual entry of dollar amount 'John Doe' has $ _____.__ child support for the month of 2010/03', etc.)				
ELIG-073	Must have ability to print case log/history in whole or designated section.				
ELIG-074	Must have ability to download case log/history to multiple formats. (e.g. excel, word, pdf, etc.)				
ELIG-075	Must have the ability view case log/history in multiple formats. (e.g. standard)				
ELIG-076	Must have ability to associate case log/history entry to multiple cases.				
ELIG-077	Must have the ability to move case log/history to another case.				
ELIG-078	Must create, retain and display case action summary/history.				

ELIG-079	Must have ability to print case file documents by user specified criteria. (e.g. type, date chronological order, by case, individual, time frame, etc.)				
	Create new intake/automatically recalculate/mass change				
ELIG-080	Must automatically perform additions, changes or deletions to defined groups without record-by record input. (e.g. mass change).				
ELIG-081	Must automatically create intakes based on information received from other sources, due to reference table changes or changed circumstance. (e.g. automatic medical for foster care, TB, refugee, MIPPA, % FPL reference table change, SSA cost of living increase, etc.)				
ELIG-082	Must automatically redetermine eligibility based on information received from other sources, due to reference table changes or changed circumstance. (e.g. automatic medical for foster care, TB, refugee, MIPPA, % FPL reference table change, SSA cost of living increase, etc.)				
ELIG-083	Must automatically redetermine changes in premiums, spenddown, and patient liability.				
ELIG-084	Must determine the correct effective date of the change.				
ELIG-085	Must automatically create alerts from mass change processing.				
ELIG-086	Must have ability to manually create intake.				
ELIG-087	Must have ability to manually redetermine eligibility.				
ELIG-088	Must have ability to create, print and send change notices from mass change determinations.				
ELIG-089	Must have ability to create and hold change notices from mass change determinations.				
ELIG-090	Must have ability to create and suspend printing of change notices from mass change determinations.				
ELIG-091	Must produce error reports from mass change processing.				
ELIG-092	Must produce action reports from mass change processing.				
ELIG-093	Must produce control reports from mass change processing.				
	Communicate/interface with other agencies/systems				
ELIG-094	Must automatically and electronically share information with non agency partners. (e.g. share penalty period information with KDOA, etc.)				
ELIG-095	Must allow the MMIS to access data for claims processing.				
ELIG-096	Must capture, retain and display all communication histories. (e.g. electronic referrals, notifications, requests for information, etc.)				

ELIG-097	Must capture, retain and display history of all interface affects. (e.g. Social Security interface, CSE interface, etc.)				
ELIG-098	Must automatically create referrals electronically. (e.g. PMDT, Working Healthy, CARE Assessment, HCBS, leaving foster care, etc.)				
ELIG-099	Must automatically create hard copy referrals. (e.g. PMDT, Working Healthy, CARE Assessment, HCBS, leaving foster care, etc.)				
ELIG-100	Must automatically attach appropriate supporting documentation to referrals.				
ELIG-101	Must have ability to create manually generated electronic referrals.				
ELIG-102	Must have ability to create manually generated hard copy referrals.				
ELIG-103	Must capture, allow change, retain and display addresses for multiple collateral contacts per case, program and member. (e.g. LTC partner, landlord, medical clinic, employer, etc.)				
ELIG-104	Must automatically create a customer release/authorization to contact.				
ELIG-105	Must automatically send a customer release/authorization to contact.				
ELIG-106	Must have ability to manually create a customer release/authorization to contact.				
ELIG-107	Must have ability to manually send a customer release/authorization to contact.				
ELIG-108	Must automatically track status of customer release/authorization to contact.				
ELIG-109	Must automatically request information from non agency partners.				
ELIG-110	Must automatically initiate data exchange request for information. (e.g. SVES request for members at age 64 and 9 months, for potential SSPP members, etc.)				
	Notices				
ELIG-111	Must have ability to select available appointment times.				
ELIG-112	Must have ability to send appointment notices to consumers or others.				
ELIG-113	Must have ability to automatically create an official request for information. Information requested to be derived from information entered by the applicant, from the case file, interface, identified by staff, etc.				

ELIG-114	Must automatically send an official request for information to the applicant and/or other party.				
ELIG-115	Must have ability to manually create an official request for information to the applicant and/or other party.				
ELIG-116	Must have ability to manually send an official request for information to the applicant and/or other party.				
ELIG-117	Must automatically create a referral to the applicant and/or other party.				
ELIG-118	Must automatically send a referral to the applicant and/or other party.				
ELIG-119	Must have ability to manually create a referral to the applicant and/or other party.				
ELIG-120	Must have ability to manually send a referral to the applicant and/or other party.				
ELIG-121	Must create and produce review forms in multiple media formats. (e.g. hard copy, electronic communication, etc.)				
ELIG-122	Must automatically populate forms. (e.g. review forms, referrals, notices, etc.)				
	LTC Specific Requirements				
ELIG-123	Must capture, allow change, retain and display all data elements required to insure appropriate payment and benefit level for members in long term care situations. (e.g. cost sharing, type of living arrangement, approved level of care, screening results, dates, etc.)				
ELIG-124	Must create, retain and display historic long term care information.				
ELIG-125	Must have ability to assign cost sharing responsibility to multiple LTC entities within a month.				
ELIG-126	Must retrieve, from the MMIS, and display on demand monthly accumulated cost sharing obligation used in claims payment. (e.g. claim ICN, amount of cost sharing obligation for this ICN, claims service date(s), provider number, claim pay date, remaining unmet patient liability/client obligation, etc.)				
ELIG-127	Must have ability to change LTC information as necessary if no claims will be affected.				
ELIG-128	Must have ability to change LTC information through special processing only when previously processed claims will be affected.				
	Spousal impoverishment specific requirements				

ELIG-129	Must identify and track spousal impoverishment assessments separately from other applications.				
ELIG-130	Must capture spousal impoverishment information.				
ELIG-131	Must automatically calculate, allow change, retain and display community spouse resource allowance determination.				
ELIG-132	Must associate spousal impoverishment information to both the LTC and community spouse upon application or reapplication.				
ELIG-133	Must capture, retain and display history of spousal impoverishment information.				
ELIG-134	Must automatically calculate, allow change, retain and display community spouse income allowance determination.				
ELIG-135	Must automatically calculate, allow change, retain and display dependent family member allowance determination.				

Proposer Fit Rating Response Codes: In the "Response" column please provide a Yes or No indicating whether or not the requirement is met. In addition to Yes or No, include a number rating indicating to what level the proposed solution meets the requirement. (Example of Response - Yes/3)

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Function: Caseload Management (CLMA) - An administrative function that focuses on assignments to workers, case transfers and workflow to support the service delivery model. Group Case Routing, Individual Assignments.

Req #	Requirement	Implementation Phase	Response	Explanation to Response	Response Reference
CLMA-001	Must have ability to monitor caseload size in real time.				
CLMA-002	Must have ability to weight cases within caseloads and provide recommended distribution.				
CLMA-003	Must have ability to establish a flexible assigned workload management hierarchy that identifies the responsible organizational unit including, but not limited to, agency, region, program, unit, specialist, county, etc.				
CLMA-004	Must have ability for more than one worker to view case information simultaneously minus concurrent updates.				
CLMA-005	Must have ability to assign work using flexible criteria. (e.g. alphabetic, program, application status, queue, weighted caseload, task, etc.)				
CLMA-006	Must have ability to transfer a single case, or a collection of cases in mass, including all electronic supporting documentation.				
CLMA-007	Must have ability to automatically create a notification of a case transfer. (e.g. options to notify customer; other needed partners; receiver; etc.)				
CLMA-008	Must allow user to manually create a notification of case transfer.				
CLMA-009	Must have ability to suppress the creation of notices of transfer. For example in the event of a restructuring of duties and an entire caseload was transferred to another worker, suppress the automatic notification of hundreds of transfers.				
CLMA-010	Must have ability to automatically evaluate a case prior to a transfer, prompt user if established transfer criteria are not met and not allow transfer until criteria is met. (e.g. no current payment authorized, etc.)				

CLMA-011	Must have ability to assign a S.P.O.C. (Single Point of Contact) to a case.				
CLMA-012	Must identify if and when a S.P.O.C. is assigned to a case so all communications go through the S.P.O.C .				
CLMA-013	Must have ability to create caseload reports such as an active case list, an active person list, pending applications, review lists, etc.				
CLMA-014	Must have ability to have a real time, comprehensive listing of workers per customer and/or case.				
CLMA-015	Must have ability to sort and display the type and number of cases assigned to a specific caseload.				
CLMA-016	Must have ability to add, subtract or modify the number of caseloads supported within the system.				
CLMA-017	Must have ability to assign a unique identifier to each caseload.				
CLMA-018	Must have ability to automatically recommend transfer or shifting of cases from one caseload to another.				

Proposer Fit Rating Response Codes: In the "Response" column please provide a Yes or No indicating whether or not the requirement is met. In addition to Yes or No, include a number rating indicating to what level the proposed solution meets the requirement. (Example of Response - Yes/3)

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Function: Quality Assurance (QARV) - The solution shall provide functionality to support Quality Assurance reviews. This includes capturing and tracking the results of individual case reviews conducted by designated staff, such as supervisors or Central Office QA staff. it also includes all federally-required reviews, including ME-QC and eligibility PERM. These requirements also include sample selection and reporting.

Req #	Requirement	Implementation Phase	Response	Explanation to Response	Response Reference
QARV-001	Must have ability to create a series of Quality Assurance case review forms to be completed and stored on the system.				
QARV-002	Must make Quality Assurance case review forms available to staff at all levels. (SRS office, Clearinghouse, out stationed, Central Office, etc.)				
QARV-003	Must provide electronic versions of Quality Case review form.				
QARV-004	Must have ability to create, modify, and terminate review forms.				
QARV-005	Must store, with the ability to retrieve, all prior versions of forms.				
QARV-006	Must have ability for Quality Assurance case review form to be completed for an individual case and stored on the system.				
QARV-007	Must have ability to populate review forms with data already on the system.				
QARV-008	Must have ability for staff to review, comment and return their own QA review forms electronically to reviewer.				
QARV-009	Must have ability to set timelines to complete reviews and responses.				
QARV-010	Must have ability to notify appropriate person(s) of approaching deadline and past due.				
QARV-011	Must have ability to notify staff when QA review form is complete.				
QARV-012	Must have ability to assign a unique number to each QA review.				
QARV-013	Must have ability to select sample based on specified parameters.				
QARV-014	Must have ability to identify the universe from which sample cases are selected for review.				
QARV-015	Must have ability to identify sample selection criteria and pull random samples.				

QARV-016	Must provide samples according to PERM regulations.				
QARV-017	Must have ability to create a pre-determined, specialized portion of case information into a special case file for review or audit that can be sent electronically. This should be flexible to accommodate different types of reviews. (e.g. Single State Audit, Federal Re-reviews, Quality Control Reviews, etc.)				
QARV-018	Must have ability to create electronic copies of portions of imaged records, attach to a review record, and send electronically. (e.g. date specific records, certain pages of multiple-page record, specific document types, etc.)				
QARV-019	Must have ability to automatically track and store records, reports, and samples historically.				
QARV-020	Must have ability to view a history of review activity.				
QARV-021	Must have ability to purge records, reports, samples, etc.				
QARV-022	Must have ability to track timeliness of completion of case review and agency/worker response.				
QARV-023	Must have ability to capture data elements related to Quality Assurance, such as causal factors, etc.				
QARV-024	Must have ability to automatically determine/recommend a causal factor based on information entered on QA Review form.				
QARV-025	Must have ability to create, modify, or delete error causal factors and case elements.				
QARV-026	Must have ability to pull reports by any data element such as review type or error causal factor from data contained in the review forms.				
QARV-027	Must have ability to automatically generate quality assurance reports.				

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Function: Cost Avoidance & Recovery (COAR) - The vendor must provide a solution that reduces incorrect payment by incorporating cost avoidance and recovery features. This module covers activities related to Third Party Liability (TPL), Child Support Enforcement (CSE), Estate Recovery Unit (ERU), Health Insurance Premium Payment System (HIPPS) and Medical Subrogation. This also includes identifying and communication with third party payment sources and the MMIS.

Req #	Requirement	Implementation Phase	Response	Explanation to Response	Response Reference
COAR-001	Must identify when a referral is required and automatically generate and track a referral.				
COAR-002	Must allow and track manually generated referrals.				
COAR-003	Must track status of referrals. Must monitor for required or expected action by receiving entity .				
COAR-004	Must accept automated and manual responses received on referrals sent and associate them with initial referral.				
COAR-005	Must retain history of all referrals sent and responses received.				
COAR-006	Must provide the ability to differentiate types of referrals within programs. (e.g. Child only CSE referrals, ERU spousal elective share, TPL lead vs. change, etc.)				
COAR-007	Must identify when a Change referral is necessary (e.g. employment changes, household changes, entering or leaving foster care, etc.) and send the referral.				
COAR-008	Must have the ability to associate a consumer notice related to the specific Cost Avoidance and Recovery area (CSE, TPL, etc).				
COAR-009	Must store a copy of the notice. These notices must be available to the work units that support these functions (CSE, TPL, etc).				
COAR-010	Must identify, generate and send potential resource situations to work unit as specified. (e.g. Annuities, Trust like Devices, Spousal Elective Shares, Personal Injury cases, Workers Comp, etc.)				
COAR-011	Must provide and display a running total of claims paid by specific claim type. (e.g. LTC payments, HIPPS premium payments, medical cash support, etc.) These claims will need to be retrieved from the MMIS.				

COAR-012	Must determine when/if TPL cooperation affects eligibility and initiate and track appropriate action.				
COAR-013	Must generate notices to capture health insurance or potential health insurance information. (e.g. when a job change occurs, automatically send requests for TPL and a HIPPS referral, etc.)				
COAR-014	Must identify, generate and send potential HIPPS candidates to fiscal agent.				
COAR-015	Must determine when/if Medical Subrogation cooperation affects eligibility and initiate and track appropriate action.				
COAR-016	Must query all available TPL sources for information.				
COAR-017	Must capture insurance information and send to MMIS as identified potential TPL lead.				
COAR-018	Must capture and send info to ERU unit automatically as specified. (e.g. Date of Death, property, length of time in nursing home, etc.)				
COAR-019	Must determine when/if ERU cooperation affects eligibility and initiate and track appropriate action.				
COAR-020	Must send Estate Recovery and similar notices automatically when a consumer dies. (e.g. notify bank accounts, funeral homes, nursing homes and responsible parties, etc.)				
COAR-021	Must be able to post payments collected to individual accounts.				
COAR-022	Must identify, capture and track trust distributions and information. Identify potential cases for further review.				
COAR-023	Must determine when/if CSE cooperation affects eligibility and initiate appropriate action.				
COAR-024	Must send detailed program level information to CSE. (e.g. individual medical subtype, etc.)				
COAR-025	Must accommodate, manage and capture medical cash support payments. This will be balanced against Unreimbursed Assistance (URA) to determine if refunds must be generated. Develop interface with MMIS, CSE system and KHPA payables unit to accomplish this.				
COAR-026	Must capture premium obligations and payments and communicate to the CSE system.				
COAR-027	Must capture birth related payments and communicate with both the MMIS and the CSE system. (e.g. historical payments, MCO, Encounter data and CAP payments, FFS, etc.)				

COAR-028	When TPL begins, ends or is updated on an individual that is shared, must send appropriate information to MMIS, CSE and the eligibility system.				
COAR-029	When Absent Parent information is known to CSE, must automatically update eligibility system with relevant absent parent info. (e.g. TPL, address, income). Allow manual update of information.				
COAR-030	Must support collection of insurance information from non-custodial parents, including those identified through CSE, by sending notices or taking other necessary action.				
COAR-031	Must automatically determine maximum cost sharing limits by individual and by family.				
COAR-032	Must automatically track cost sharing responsibilities to determine if a maximum threshold has been reached. (e.g. a family cannot be charged more than 5% of income, system must track cost-sharing responsibilities and issue an alert when the maximum has been reached.)				

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Function: Incorrect Benefits & Collections (COPO) - This function supports account establishment, collections, adjustments, reversals, transfers, and maintenance. Account investigation and similar activities related to correcting over or under payments to a customer or other entity. Need to interface with other state and contractor financial systems.

Req #	Requirement	Implementation Phase	Response	Explanation to Response	Response Reference
COPO-001	Must have ability to retain benefit history by type of benefit provided such as supplemental, QMB, Title 19 Medicaid.				
COPO-002	Must have ability to create and provide benefit issuance history reports.				
COPO-003	Must have ability to capture the overpayment and store by funding codes (e.g. An overpayment is determined and some of the claims that were paid were for KDOA funded services and also KHPA funded services, etc.)				
COPO-004	Must have ability to automatically determine a period of incorrect eligibility. (e.g. Paid Title 19 when correct eligibility should have been Title 21, Paid Title 19 when not eligible at all, etc.)				
COPO-005	Must have ability to automatically determine a medical overpayment has occurred.				
COPO-006	Must have the ability to automatically determine the amount of an overpayment using information available in K-MED for example, patient liability amounts, premiums and resource levels are found in K-MED.				
COPO-007	Must have the ability to automatically or manually send a request to the MMIS for medical payments to be used to determine the overpayment. E.g. Medical claims paid, capitated managed care payments, Medicare Buy-In payments for the overpayment period.				
COPO-008	Must have the ability to adjust overpayment amounts based on updates to paid claim amounts coming from the MMIS.				
COPO-009	Must send an indicator to the MMIS when a claim is used to establish and/or collect an overpayment.				

COPO-010	Must have ability to automatically determine medical underpayment occurred.				
COPO-011	Must have ability to automatically determine amount of underpayment using information available in K-MED.				
COPO-012	Must have the ability to automatically or manually send a request to the MMIS for medical payments to be used to determine the underpayment.				
COPO-013	Must determine the most appropriate method to resolve the underpayment. For example, an overstated patient liability could result in a refund to a member if the MMIS has paid a claim using the previous patient liability or could be resolved by reducing a future month's patient liability.				
COPO-014	Must automatically track and monitor overpayments by type (e.g. program, funding source, consumer, case, etc.).				
COPO-015	Must have ability to set recovery method including amounts to be recouped and payment schedule.				
COPO-016	Must have ability to retain all data used in the calculation of incorrect benefits.				
COPO-017	Must have ability to transfer an overpayment from one program to another.				
COPO-018	Must have ability to automatically and/or allow the user to manually deactivate overpayment. (e.g. bankruptcy, paid in full, or death, etc.)				
COPO-019	Must have ability to track status of overpayment from investigation through closure.				
COPO-020	Must have ability to associate the medical overpayment to the premium collection system to increase premiums or withhold refunds.				
COPO-021	Must automatically track all incorrect payment data, activities and audit trail.				
COPO-022	Must have ability to delete or reverse an overpayment.				
COPO-023	Must have ability to track root cause of incorrect payments and create reports. (e.g. coding errors, policy application errors, etc.)				
COPO-024	Must have ability to transfer an overpayment from one customer to another.				
COPO-025	Must have ability to transfer an overpayment from one case to another.				

COPO-026	Must have ability to use an underpayment to pay an overpayment balance. (e.g. If a patient liability is determined to be incorrect for several months, the amount of the difference between the incorrect and correct liability can be used to reduce an outstanding previously established overpayment, etc.)				
COPO-027	Must have ability to auto generate a notification of overpayment account activity including status, billing notice, receipts and payment history.				
COPO-028	Must have ability to record receipt of payments made through various methods. (e.g. cash, check, various online bill pay, credit card, automatic deduction, garnishment, etc.)				
COPO-029	Must have ability to increase patient liability to satisfy an overpayment.				
COPO-030	Must have ability to initiate a request for refund when the overpayment is overpaid.				
COPO-031	Must have ability to identify the other programs the customer or other household members participated in during the overpayment time period.				
COPO-032	Must have ability to produce the data extract to support federal reports related to overpayment recoveries.				
COPO-033	Must have ability to identify if case is subject to estate recovery.				
COPO-034	Must have ability to automatically create, change, retain and display a special spenddown to recover an overpayment.				
COPO-035	Must allow the user to manually create and change a special spenddown to recover an overpayment.				

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Function: Hearing & Appeals (HEAP) - The vendor's solution must support request to review an agency decision or action. This includes administrative appeals (fair hearings), fraud hearings and grievances.

Req #	Requirement	Implementation Phase	Response	Explanation to Response	Response Reference
HEAP-001	Must be able to receive concerns through multiple channels. (e.g. phone, e-mail, letter, fax, etc.)				
HEAP-002	Must provide an electronic template for concerns that is accessible through the web.				
HEAP-003	Must automatically capture, retain, and display receipt of a concern.				
HEAP-004	Must allow manual entry of a concern.				
HEAP-005	Must automatically record the reporter/source (name, address, associated agency of person expressing the concern, etc) if available.				
HEAP-006	Must allow manual entry of the reporter/source. (e.g. name, address, associated agency of person expressing the concern, etc.)				
HEAP-007	Must assign a system - generated tracking number to the concern that uniquely identifies it.				
HEAP-008	Must have ability to identify and assign the priority of a concern.				
HEAP-009	Must automatically associate the concern to a case(s) and /or an customer(s).				
HEAP-010	Must track concerns that can not be associated with a case or customer.				
HEAP-011	Must track all concerns.				
HEAP-012	Ability to track multiple concerns from a single contact.				
HEAP-013	Must store all concerns in a central location.				
HEAP-014	Must record and track concerns outside of the standard case log.				
HEAP-015	Must automatically include information in the case log.				

HEAP-016	Must have ability to note critical information regarding a concern (annotate).				
HEAP-017	Must capture and sort history of concerns by multiple parameters. For example, sort and track by source (including reporter/agency submitting concern), by subject (including case, person, program), by date, etc.				
HEAP-018	Must have ability to associate additional details to an original concern and record who added the details.				
HEAP-019	Must automatically cross reference common concerns. (e.g. receiving 100 fair hearing requests from a single appellant on a single policy change.)				
HEAP-020	Must have the ability to cross reference common concerns. (e.g. receiving 100 fair hearing requests from a single appellant on a single policy change.)				
HEAP-021	Must track when a concern becomes a fair hearing request.				
HEAP-022	Must have the ability to assign a worker, or group of workers, to manage a concern.				
HEAP-023	Must have ability to change the manager of a concern.				
HEAP-024	Must have ability to involve others in the management or resolution of a concern, including assignments to outside third parties.				
HEAP-025	Must identify the staff who are assigned to perform work on the concern.				
HEAP-026	Must have ability to generate a referral to a third party assignee. (e.g. regular letter, email, automated referral, etc.)				
HEAP-027	Must have ability to require a response by the third party assignee on a case by case basis.				
HEAP-028	Must automatically alert appropriate staff when action is needed or information is due to ensure timely processing of the concern.				
HEAP-029	Must automatically notify customer, third party entity, worker, etc. that the status of a concern has changed. (e.g. pending hearing, withdraw, referred, etc.)				
HEAP-030	Must have ability to manually notify customer, third party entity, worker, etc. that the status of a concern has changed. (e.g. pending hearing, withdraw, referred, etc.)				
HEAP-031	Must automatically notify the customer that their concern has been received and who it has been referred to.				
HEAP-032	Must have the ability to manually notify the customer that their concern has been received and who it has been referred to.				

HEAP-033	Must automatically notify someone other than a customer of a concern. (e.g. authorized medical representative, etc.)				
HEAP-034	Must have ability to manually notify someone other than a customer of a concern. (e.g. authorized medical representative, etc.)				
HEAP-035	Must prompt user when additional information is needed.				
HEAP-036	Must automatically send reminders (e.g. alerts, letters, e-mail, etc) to communicate with staff, witnesses, third party entities, etc.				
HEAP-037	Must allow designated users to have electronic access to paperwork associated to concerns.				
HEAP-038	Must automatically gather appropriate documents and key information for fair hearing summary upon receipt of request.				
HEAP-039	Must auto populate fields. (e.g. summary, request for dismissal, fraud referral, etc.)				
HEAP-040	Must automatically generate hearing forms. (e.g. request, dismissal, summary, etc.)				
HEAP-041	Must have ability to manually generate hearing forms, e.g. request, dismissal, summary, etc.				
HEAP-042	Track paid months affected by the appeal process and calculate any overpayment.				
HEAP-043	Must track incorrectly paid or unpaid months affected by the appeal process and calculate any underpayment.				
HEAP-044	Must track collections for customer, specific hearing, fraud finding etc.				
HEAP-045	Must automatically transfer information to the HP Fair Hearings Database.				
HEAP-046	Must receive information from the HP Fair Hearings Database				
HEAP-047	Must coordinate information exchange with the HP Fair Hearings Database to minimize the capture of duplicate information.				
HEAP-048	Must track fair hearings and fraud hearings separately.				
HEAP-049	Must have ability to identify and track a case undergoing a fraud investigation.				
HEAP-050	Must track fraud occurrences that are tied to a customer.				
HEAP-051	Must track fraud status, e.g. information sent in, scheduled, penalty period, settled, etc.				
HEAP-052	Must identify trends by using defined parameters.				
HEAP-053	Must report the number of hearings.				

HEAP-054	Must provide multiple reports to include, but not limited to, fraud hearings, number and type of decisions.				

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Function: Presumptive Medical Disability Determination - This module covers KHPA disability determination processes.

Req #	Requirement	Implementation Phase	Response	Explanation to Response	Response Reference
PMDD - 001	Must include the PMDD Questionnaire as part of the on-line application, so persons meeting the criteria for PMDD will be directed to answer additional questions.				
PMDD - 002	All PMDD forms must be available for the consumer to print.				
PMDD - 003	Electronic forms will be available for specific PMDD forms.				
PMDD - 004	Capture electronic signatures.				
PMDD - 005	Automatically generate and send a referral to the PMDT when necessary.				
PMDD - 006	Identify previous PMDD referrals and decisions.				
PMDD - 007	Automatically set an accelerated flag using factors such as age and allegations.				
PMDD - 008	Ability to manually set an accelerated flag.				
PMDD - 009	Allow applicant to electronically submit documents that go directly to the PMDT.				
PMDD - 010	Create and retain a PMDD record for each individual.				
PMDD - 011	Maintain PMDD file separately from 'regular' medical case file.				
PMDD - 012	Link PMDD file with 'regular' medical case file.				
PMDD - 013	Limit access to PMDD file by role.				
PMDD - 014	Provide multiple security views of the PMDD record.				
PMDD - 015	Automatically generate a paper request for medical records that also allows a staff person to complete missing information (e.g. Populate name and address of medical provider or completes the contact information but allows the worker to ask for specific medical records needed.				
PMDD - 016	Ability to search and generate interview or appointment times when an interview or appointment is necessary.				
PMDD - 017	Send reminders to staff of upcoming interviews or appointments.				

PMDD - 018	Ability to automatically identify, capture, set and change referral type and status.				
PMDD - 019	Automatically change referral type/status.				
PMDD - 020	Ability to manually capture and change referral type and status.				
PMDD - 021	Must capture all relevant dates in the PMDD process, including the referral received date, questionnaire received date, medical record request date, referral to DDS date, determination date etc.				
PMDD - 022	Must track all relevant dates and timeframes in the PMDD process.				
PMDD - 023	Must provide a separate workflow process(s) for the PMDT.				
PMDD - 024	Must have a flexible workflow, monitoring and tracking tool to support the various status/paths a case may take.				
PMDD - 025	Must have the ability for each referral type/status to have a unique workflow.				
PMDD - 026	Must have the ability to send notices to one or multiple entities at the same time.				
PMDD - 027	Automatically send a questionnaire and other forms when needed .				
PMDD - 028	Ability to manually send a questionnaire or other forms when needed.				
PMDD - 029	Must have the ability to automatically identify information missing from the PMDD case record.				
PMDD - 030	Ability to manually generate a request for information that is missing.				
PMDD - 031	Must have the ability to establish different referral types/statuses.				
PMDD - 032	Must have the ability to use information received through an interface (for example SSA info) to determine PMDD eligibility.				
PMDD - 033	Must have the ability to request medical records from Doctors/providers.				
PMDD - 034	Must store doctor/provider identifying information such as NPI, address, phone number, contact person, etc.				
PMDD - 035	Must have the ability to create referrals to DDS or have DDS view the information in the K-Med system and enter their decision directly in K-MED.				
PMDD - 036	The ability to create invoices for medical record requests.				
PMDD - 037	The ability to send invoices to SMART for payment.				
PMDD - 038	Must be able to access and import medical records/documents from FTP or internet sites.				

PMDD - 039	Must have the ability to send final decision to multiple entities.				
PMDD - 040	Must have the ability to capture and display disability determination information.				
PMDD - 041	Capture and track Social Security disability decision throughout the life of the determination				
PMDD - 042	Must be able to display the history of each status by date and staff/process that assigned the status.				
PMDD - 043	Must produce reports to reflect pending work load by current status, at the worker/unit/operation level.				
PMDD - 044	Must produce reports to reflect pending work load by referral type and at the worker/unit/operation level.				
PMDD - 045	Must produce reports to reflect completed work by referral type and at the worker/unit/operation level.				
PMDD - 046	Must produce reports to reflect timeliness of work completed at the worker/unit/operation level.				
PMDD - 047	Must have the ability to produce ad-hoc reports using all data elements for both the PMDD module and other K-MED data elements.				
PMDD - 048	Produce reports comparing the PMDD decision with the actual disability decision made by SSA.				
PMDD - 049	Must have the ability to search the determination history by date, status etc.				